Highland Park *Spine & Sports Medicine*

Patient Summary

PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: _____

Age: _____ Date of Birth: _____ / _____ / _____ Sex: ☐ Male ☐ Female

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PROVIDER COMPLETES THIS SECTION:

Date you want this submission to begin: _____ / _____ / _____

Patient Type: ☐ New to your office ☐ Est'd, New Injury ☐ Est'd, New Episode ☐ Est'd, Continuing Care

Nature of Condition: ☐ Initial Onset (within last 3 months) ☐ Recurrent (multiple episodes of 3 months)
☐ Chronic (continuious duration 3 months)

Cause of Current Episode: ☐ Traumatic ☐ Unspecified ☐ Repetitive ☐ Work Related ☐ Motor Vehicle
☐ Post-surgical:
Date of Surgery: _____ / _____ / _____
Type of Surgery: ☐ ACL Reconstruction ☐ Rotator Cuff/Labral Repair ☐ Tendon Repair
☐ Spinal Fusion ☐ Joint Repair ☐ Other: _____

Diagnosis (ICD Code) *Please ensure all digits are entered accurately:*

1° ☐☐☐.☐☐ 2° ☐☐☐.☐☐ 3° ☐☐☐.☐☐ 4° ☐☐☐.☐☐

Height: _____-_____ Weight: _____ Blood Pressure: _____ Temperature: _____

DC Only

Anticipated CMT Level: ☐ 98940 ☐ 98941 ☐ 98942 ☐ 98943

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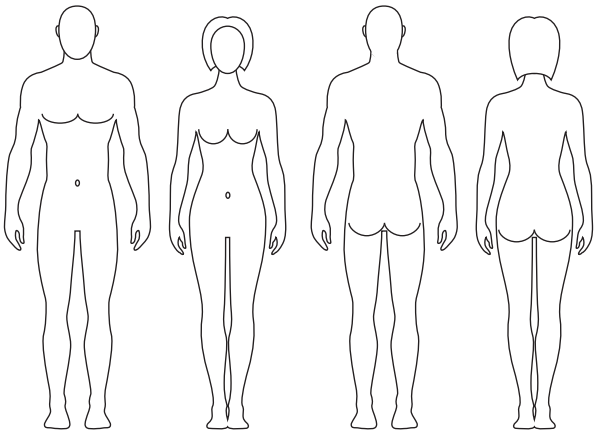
Patient Summary

PATIENT COMPLETES THIS SECTION:



Please indicate where you have pain or other symptoms

Date symptoms began: _____ / _____ / _____

1. Please describe the current complaint:

_____

_____

2. Average pain intensity *(1 being lowest pain, 10 be the highest, please circle)*:

0 1 2 3 4 5 6 7 8 9 10

3. Please describe how your symptoms started:

_____

_____

4. How often do you experince your symptoms?: ❑ Constantly (76%-100% of the time) ❑ Frequently (51%-75% of the time) ❑ Occasinally (26%-50% of the time) ❑ Intermittently (0%-25% of the time)

5. Please describe your current pain/symptoms:

aching	annoying	burning	cramping	deep
dizzy	dull	headache	numbness	pinching
pins and needles	pinprick	popping	radiating	sharp
sharp with movement	shooting	stiff	sore	spasm
stabbing	throbbing	tingling	tight	weakness
other _____				

6. What makes your problem worse? (aggtavating factors):

airplane travel	bending	computer work	coughing	cycling
driving	exercise	golfing	high kicking	household chores
inactivity	lateral bending	laying on side	looking up	looking down
lifting	lying down	movement	nothing aggravates	reaching
rotational looking	running	sitting	standing	stooping
sleeping	sneezing	straining	stair stepping	tennis
twisting	stress _____	throwing	squatting	walking
wearing high heels	other			

7. What makes your problem better? (relieving factors):

analgesic/topical	chiropractic	heat is applied	ice is applied	lying down
massage	movement occurs	no movement occurs	nothing improve	rest occurs
sitting	standing	stretching	stretching/exercise	walking
other _____				

8. How much have your symptoms interfered with your usual daily activities?:

❑ Not at all ❑ A little bit ❑ Moderately ❑ Quite a bit ❑ Extremely

9. How is your condition changing since care began at our facility?:

❑ N/A First visit ❑ Much worse ❑ Worse ❑ A little worse ❑ No change ❑ Better ❑ Much better

10. In general, would you say your overall health right now is:

❑ Excellent ❑ Very good ❑ Good ❑ Fair ❑ Poor

Patient's signature: _____ Date: _____ / _____ / _____